WISCONSIN MEDICAID
PRIOR AUTHORIZATION / OXYGEN ATTACHMENT (PA/OA)

Providers may submit prior authorization (PA) requests by fax to Wisconsin Medicaid at (608) 221-8616, or providers may send the completed form with attachments to: Wisconsin Medicaid, Prior Authorization, Suite 88, 6406 Bridge Road, Madison, WI 53784-0088. **Instructions:** Type or print clearly. Before completing this form, read the Prior Authorization/Oxygen Attachment (PA/OA) Completion Instructions, HCF 11066A. Providers are required to attach a completed Record of Actual Daily Oxygen Use form, HCF 11067, or a copy of the recipient's oxygen use records to the PA/OA for recipients who reside in a nursing home.

SECTION I — PROVIDER INFORMATION

1. Name — Medical Equipment Vendor	2. Medical Equipment Vendor's Medicaid Provider No.
3. Telephone Number — Medical Equipment Vendor	4. Requested Start Date
5. Name — Person Completing Form	6. Title — Person Completing Form
7. Name — Prescribing Physician	8. Prescribing Physician's Medicaid Provider No. or Universal Provider Identification Number
9. Address — Prescribing Physician (Street, City, State, and Zip Code)	10. Telephone Number — Prescribing Physician

SECTION II — RECIPIENT INFORMATION

11. Name — Recipient (Last, First, Middle Initial)	12. Recipient Medicaid Identification Number
13. Height and Weight — Recipient Height _____ inches Weight _____ lbs	14. Date of Birth — Recipient
15. Place of Service (choose one) ❑ 11 = Office ❑ 12 = Home ❑ 31 = Skilled Nursing Facility ❑ 32 = Nursing Facility ❑ 99 = Other Place of Service	16. Name and Address — Facility (if applicable)

SECTION III — CLINICAL INFORMATION

17. Estimated Length of Need (1-98 months; 99 = Lifetime) _____ months	18. Diagnosis — Codes and Descriptions Primary — Secondary —

19. Qualifying Test — Enter results of test taken within 60 days prior to the date of submission or requested start date of the PA request. Test results are to be available in the recipient's record or case file. **Note: Criteria for coverage of oxygen-related services include either an oxygen saturation level (SAO_2) of 88 percent or lower or an arterial blood gas level (PO_2) of 55 mm/Hg or lower.**

a) Date ____/____/_____ (MM/DD/CCYY)

b) Recipient condition during test (choose one)
❑ At rest ❑ During exercise ❑ During sleep

c) Arterial blood gas level (PO_2) _____ mm/Hg

d) Oxygen saturation level (SAO_2) _____ %

e) Name, Address, and Credentials — Provider Performing Qualifying Test

(Continued)

SECTION III — CLINICAL INFORMATION (cont.)

20. Enter the oxygen liter flow rate / number of hours per day as prescribed by the physician.

a) _____ Liters per minute

b) _____ Hours per day

c) _____ Days per week

d) _____ Continuous

e) _____ PRN, describe circumstances and frequency of use —

21. Type of Oxygen Prescribed
- ❑ Concentrator
- ❑ Liquid
- ❑ Gaseous

22. Means of Delivery Prescribed
- ❑ Nasal Cannula
- ❑ Mask
- ❑ Other (Specify) _____

23. Indicate portable oxygen and recipient mobility information, if applicable.

a) Is portable oxygen prescribed? ❑ Yes ❑ No ❑ N/A

b) If portable oxygen is prescribed, is the recipient mobile? ❑ Yes ❑ No ❑ N/A

c) If the recipient is mobile and portable oxygen is prescribed, describe to what extent the recipient is mobile.

24. If the recipient's arterial blood gas level (PO_2) is 56 mm/Hg or above or the recipient's oxygen saturation level (SAO_2) is 89 percent or above, answer questions a-d.

a) Does recipient have clinical evidence of chronic or recurrent congestive heart failure? ❑ Yes ❑ No ❑ N/A

b) Does recipient have cor pulmonale or pulmonary hypertension documented by P pulmonale on an electrocardiogram or by an echocardiogram, gated blood pool scan, or direct pulmonary artery pressure measurement? ❑ Yes ❑ No ❑ N/A

c) Does recipient have clinical evidence of decubital angina? ❑ Yes ❑ No ❑ N/A

d) Does recipient have erythrocythemia with a hematocrit greater than 56 percent? ❑ Yes ❑ No ❑ N/A

25. Describe the medical condition of the recipient that supports the use of oxygen (e.g., describe why the recipient needs this equipment).

SECTION IV — PHYSICIAN PRESCRIPTION

26. Date of Prescription (MM/DD/CCYY)

27. Prescription as Written

If the prescribing physician signs the PA/OA, Wisconsin Medicaid will accept it in lieu of the physician's written prescription and there is no need to attach a photocopy of the prescription to the PA/OA. The prescription or this attachment must be signed and dated by the physician within 30 days prior to the date of receipt by Wisconsin Medicaid or the requested start date of the PA request.

28. **SIGNATURE** — Prescribing Physician

29. Date Signed

Reset Form